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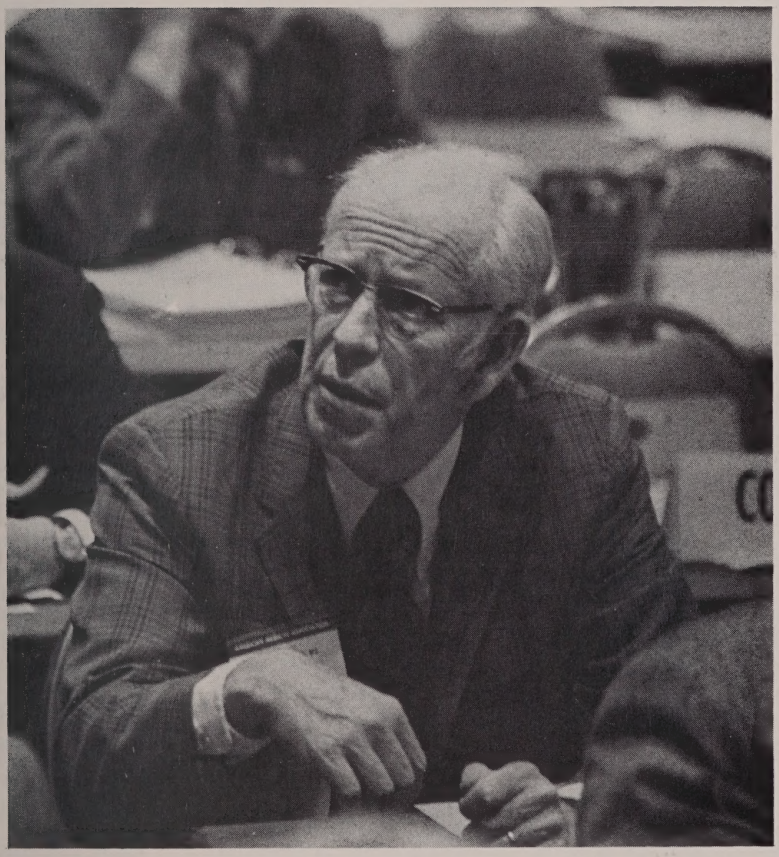

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THE HAMPDEN HIPPOCRAT
·1942·

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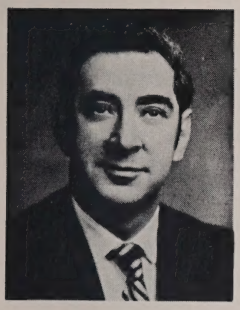

Your President's Page

P.S.R.O–

–The Law Of The Land

On November 30, 1973, the medical societies of Western Massachusetts had the distinct opportunity to listen, first hand, to U.S. Senator Wallace F. Bennett, regarding Title XI of the Social Security Act as ammended by Public Law 92-603, with his authorship of section 213, better known as P.S.R.O. (Professional Standard Review Organization) The Senator made it quite clear in his presentation and during the period of questions and answers that P.S.R.O. *is* the *law of the land.* In a personal way to me, as I drove him from the airport to our meeting, he hoped that P.S.R.O. was not construed to be a punitive measure to the physicians of our country, but initiated to maintain and improve the quality and cost of medicine to all citizens of our land, whatever their socia-economic level. He re-emphasized to me that he was placing peer review in the hands of the physicians, where it truly belonged, *not* in the hands of the lay public, hospital administration or third party insurance carriers.

Doctor Henry Simmons, Assistant Secretary for Health and Acting Director of the Office of P.S.R.O. has stated, that by January 1, 1974, all area designations of P.S.R.O., within established Foundations, throughout our country, would be announced. By January 1, 1976, the full impact of Public Law 92-603 will become operational. You may well ask the scope and dimensions of P.S.R.O. The effects will be on approximately 50 million recipients of Medicare and Medicaid who are admitted to our hospitals. It will mean the expenditure of 22 billion dollars in Federal and State monies for these groups of patients. Approximately 7200 hospitals, 14,000 skilled and semi-skilled nursing and intermediate care facilities and 500 mental hospitals will be involved. Approximately 335,000 practicing physicians and osteopaths and 100,000 dentists, 7000 podiatrists, 18,300 optometrists, 7,000 clinical psychologists, 15,000 physical therapists, 7,500 occupational therapists and 16,000 chiropractors will participate under the jurisdiction of this law.

The Federal mandate will require the review of physicians, dentists and all other providers and patient profiles, the advance review of elective admissions to hospitals or other care facilities, certifications of need for hospitalization and continuation for extended treatment, inspection and assessment of the health care facility and review of physician records when pertinent to a particular review process. If and when National Health Insurance comes to pass, you can be certain that the Bennett Amendment will involve 210 million Americans who are admitted to hospitals and undoubtedly extend directly into our office practice.

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Physicians in our own district and throughout our land are very concerned about P.S.R.O. Some look upon it as invasion of the privacy of physician and patient; some feel it is unconstitutional, others reject the idea of "norms" and establishment of profiles and computerizing both the doctor and the patient and his illness into a drum. The physician, rightfully so, is concerned that the quality of medicine will deteriorate and be bartered by the Federal bureaucracy for the sake of cost control. The expenditure for Health care will exceed 80 billion dollars at the end of this year and the Federal Government and States will be responsible for over 40 per cent of this amount. Whenever tax dollars are spent and the private citizen begins to pay out of his own pocket monies, (for whatever reason) he rightfully should get an accounting of how it is spent!

Each physician has the freedom of thought and expression and as your President, I express my own. The enactment of peer review by this law is not new to us. In our own district as well as our State and National Medical Societies, physicians have always reviewed their peers, much before governmental intervention. Almost all hospitals have tissue committees, utilization reviews which have been in function for years. As physicians, have we not provided the history and findings and operative notes of our patients? Has not the privacy of doctor-patient relationship been invaded and eroded over the years by the demands of third party payers? For years each physician has been profiled and categorized by insurance carriers. The P.S.R.O., in essence, is asking the same, but insisting that we justify our standard of health delivery and the conduct of practice within certain norms, in our own community of physicians and patients. If you are well trained and maintain continued medical education for your own betterment and that of your patient, why then should you become distraught over peer review by your own district or one established by the government through your own *Foundation?*

We as physicians are idealistic and deeply moved by all human suffering but at the same time we tend to be very individualistic and abhor being marshalled and regimented. I for one will not abandon the former attributes. I do not feel that my individualism is threatened if I can work cohesively within the context of the law of the land; *see how* it *functions* and *improve upon it,* if it undermines the quality of medicine to my patients. I have not succumbed in defeat as a wounded warrior, for P.S.R.O.—the law of the land has not denied me the ability to attend to the ills of my patient nor to dress his wounds. It has only asked that I justify my practice of the art of medicine, when called upon by my peers.

S. A. Zacarian, M.D.

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EDITORIAL . . .

A Legislative Issue

The February Issue of your Hampden Hippocrat is again devoted to Commonwealth Legislation as it affects and effects your medical practice. Dr. Maurice J. Boivin is chairman of your Legislative Committee and it is one of his duties to apprise the Executive Committee and the membership of important legislation and to brief us on what, if any, action is to be undertaken either as individuals or as part of organized medicine.

In the MMS Council Meeting of October 10, 1973, which was held in western Massachusetts several resolutions put forth by members of the Hampden District Medical Society were amply discussed and the Council was again alerted to the problem caused by the rewriting of Rules and Regulations by the Department of Public Health. Two key and vital resolves were approved and are hereafter printed. They prove that the Council can act effectively for the good of all physicians.

"That the Massachusetts Medical Society formulate a plan which will insure the highest quality care without restriction of patient or physician rights through Department of Public Health regulation."

"That the President appoint an ad hoc committee to formulate and carry out plans to curb the increasing Department of Public Health tendency to infringe upon the rights of physicians to treat patients in a manner and in a place of the choosing of the physician and the patient. The charge to the committee includes the right to engage legal counsel."

To those readers with access to Draft #6 and Draft #7 (Final Draft) of *Rules and Regulations for Cancer Management in Hospitals and Clinics,* they will note a substantial change in the phrasing and directives of this momentous reorientation for cancer management in the Commonwealth. As chairman of a committee charged with preparing a master plan for *Cancer Management and Treatment for Western Massachusetts* by the Western Massachusetts Health Planning Council, I find the final draft much easier to work with and that it lends itself far better to the unique conditions here in the four western counties. What forces were active behind the scenes during the last revision are unknown to me, but I would like to think that the Council's actions and resolves were partially instrumental in the improved draft!

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Two basic issues remain to be settled. The first relates to the lack of input from organized medicine i.e. the Massachusetts Medical Society and its speciality divisions, in assisting the Department of Public Health to revise its Rules and Regulations. The physician members of the committees chosen to rewrite and update licensure standards often do not represent the elected leaders from organized medicine but seem handpicked by the Department. Is bias avoided? The second issue is bitter-sweet and relates to the method in which the Department is changing and (often) limiting the practice of medicine by redefining the groundrules for licensure of hospitals. No one can disagree that periodic updating and upgrading of the standing R & R's is essential to modernization of the hospital practice of medicine. But is not the input from the Massachusetts Hospital Association and the Massachusetts Medical Association also vital so that an equitable final draft is obtained? These basic issues do not fall into the legislative section of our government but represent maneuvers, with the force of law, initiated by the executive branch; therefore are they constitutional?

For consideration by the membership and eventually the Great and General Court is the need for revision of the statues which apply to the granting and removal of physicians' licenses to practice medicine. Although it should not be a prerogative of organized medicine to decide who gets and keeps a license, medicine's voice should be stronger. Peer review has revealed that physicians no longer capable of practicing effectively can not be eased into less visible practice positions. There is no active mechanism wherein the patient is assured that "his doctor" has kept up nor is there a mechanism wherein the unethical physician can be *delicensed.* If we do not do it ourselves, it will be done for us and the conditions will not be to our advantage. That same old cry—must it always go unheeded?

The task of keeping up with Beacon Hill is monumental and the MMS has enlisted the services of Mr. John Noonan. His background "on the hill" should stand us well. One of the tasks of our own president-elect will be to see that further positive progress is made toward the equitable solution of the differences which exist between organized medicine, the Department of Public Health and the legislators on Beacon Hill. He is assured of this editor's support.

W. E. STEVENS, M.D. Editor-in-chief

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MMS Beacon from the Hill

Mr. John D. Noonan is the Legislative Representative for the Massachusetts Medical Society. His constant surveillance and research into what is happening on Beacon Hill keeps the Society up to date on health care legislation. This is no easy task as there are more than five thousand different pieces of legislation filed for consideration at each session of the House and Senate. After sifting through all of these bills, Mr. Noonan condenses the pertinent information concerning the health care bills and forwards it to the local medical societies. Each local medical society has a Legislative Committee which studies the information received and takes action by sending letters to the legislators opposing or supporting the individual bill. Last year Hampden District Medical Society considered over one hundred bills and took action on many. For example, your local Society supported H 186 (to insure high quality emergency medical care through regulation of ambulances and ambulance services) and opposed H 6315 (the Governor's bill to reorganize Blue Shield). This "grass roots" communication to the legislators is vital to the medical community if it wishes to actively participate in the legislation which governs it.

Mr. Noonan holds a Master of Science Degree in Public Relations and a Bachelor of Science Degree in Journalism from Boston University. He has taken scientific evening extension courses at Harvard, MIT, and Northwestern Universities. He is a former newspaper writer, political columnist, and editor of the Quincy newspapers. He was Coordinator of Health Education for the Massachusetts Department of Public Health. Previous to his present post, he was the Associate Director of Public Relations for the Massachusetts Medical Society. He is a member of the Public Relations Society of America, the Boston Publicity Club, the American Association of Medical Society Executives, and is Chairman of the Public Affairs Committee of the Massachusetts Health Council.

On a more personal note, Mr. Noonan is married, has three children, and is the proud grandfather of two. He has a rather special interest in the western portion of the state as his youngest daughter, Barbara, is studying nursing at the University of Massachusetts in Amherst. The Women's Auxiliary to the Massachusetts Medical Society was delighted to have Mr. Noonan as the guest speaker at their Winter Conference on Thursday, January 31, at the Baystate West Motor Hotel, Springfield, Mass.

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ARTICLE:

Federal Health Care Can PSRO's Contain Its Cost?

Unquestionably one of the intents of the PSRO legislation is to contain the cost of health care provided to Medicare and Medicaid recipients.

Under the present system it seems hardly possible that this aim can be reached as it has become quite evident to doctors and hospital administrators who, remote from the activities of Legislative bodies have to cope with the arduous task of ultimately providing the services.

The following considerations are based on data obtained through EDP system in a medium-large (365 beds—no obstetrics) community hospital in the northeast for the year 1972 and the first six months of 1973. Because of its type, this hospital represents a good cross-section of hospitals throughout the United States providing services to Medicare and Medicaid patients.

This institution has had for many years a very active Utilization Review Committee with more than perfunctory functions, reinforced during recent months by the adoption of a sophisticated program of Medical Care Evaluation in compliance with the requirements of Puvlic Law 92-603.

While the average length of stay for patients 65 years or younger is down to 7.5 days, therefore including the bulk of patients covered under Medicaid, for patients 65 years or older, the average length of stay remains at 12.5 days. Although these older patients accounted for 25% of all hospital admissions, they accounted for 38% of total patient days. The majority of them were suffering from: (cont.)

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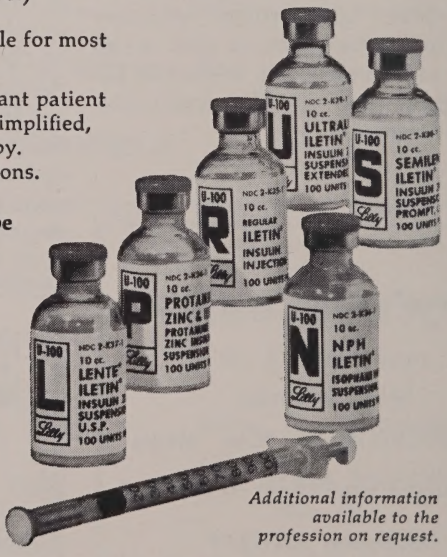

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Considering the nature of these conditions, the need for acute hospitalization should not have extended to more than a few days and certainly not beyond the average length of stay noted for all other patients.

The above statement might be contested on the accepted grounds that the older the patient, the longer it will take to restore his health; however, this is a fallacy when applied to the disease categories listed above, many of which are already of a chronic nature when patients are hospitalized and for which the outcome is hardly expected to be a definite cure.

Because of better cooperation on the part of physicians who, over a period of a few years have been made utilization conscious, the average length of stay for patients 64 years or younger has decreased gradually to a level which medically speaking perhaps cannot be lowered any further. The same cannot be said in regard to older patients whose length of hospitalization seems to remain more or less unchanged.

Looking into the reasons why these patients remain so much longer than it would appear necessary in an acute hospital, the following determining factors readily emerge:

Because of the very nature of the previously mentioned diseases, after a period of hospitalization many patients will continue to require prolonged care (rehabilitative, supportive or palliative) which can only be provided adequately in Skilled Nursing Facilities.

While this axiomatic eventually is well recognized and responsibly accepted by Medicare, in actual practice the discharge of a patient to a Skilled Nursing Facility becomes an unbelievably lengthy and laborious process.

Patients who require the same high level of care for a longer period than allotted by Medicare, or those for whom the level of care after a period may fall below the level necessary to qualify for Medicare coverage are potential threats to a long-term care facility since they could become either a problem of further disposition or outright fiscal liabilities. To protect themselves against such eventualities these institutions will not accept any patient until present and future fiscal responsibility has been clearly established.

Regardless of Health Planning Councils' statements to the contrary, in many areas there is an absolute shortage of Skilled Nursing Facility beds. Where these facilities do exist, stringent and often unreasonable enforcement of standards by Medicare regulatory agencies have deterred many such facilities from seeking Medicare certification status and, in fact have compelled some of them to ask for decertification after a period of prolonged harassment.

Whenever a Medicare certified SNF bed is not available the only alternative is to try placement into a known certified long-term care facility. Since the majority of these elderly patients are financially insolvent they will have to seek welfare help. The procedure required is also quite involved and certainly time consuming, requiring anywhere from one to three weeks and with no warranty that in the end an available bed will be found. Many of these patients will be placed on a waiting list of city or state run long-term care facilities for a further waiting period.

During 1972, 460 patients 65 or older were transferred to Extended Care Facilities. At an average length of stay of 12.5 days they accounted for 5,750 patient days. This figure could very well be conservative on the minus side since, at the moment of this writing, I do not have available precise information as to how long in fact these patients remained waiting in the hospital beyond the 12.5 days.

(cont.)

Considering the time required for the transfer process, according to the experience of our Social Service, it would seem pretty accurate to assume that these patients remained in the hospital for at least an average period of ten days beyond the 7.5 day average length of stay for all other categories of patient.

Based on these figures, these patients accounted for 4,600 patient days after the need for acute hospital care had ceased. If timely transfer could have been accomplished this would have resulted in a saving of as many days, or $460,000.00 for 1972. If we were to multiply this figure by 3,000 which is the approximate number of medium-sized or larger acute general hospitals in this country we would reach the staggering figure of $1,380,000,000.00. This much the Federal government would have saved in one year for the care of Medicare recipients in short-term hospitals if adequate facilities for long-term care had been available. Granted that some of this would have been spent to pay for a lower level of care, still a substantial amount would have been saved and a better utilization profile would have been obtained to help project the actual need for short-term hospital beds in the future when a system of National Health Insurance might be established.

The Medicare program is a form of Health Insurance with responsibilities limited within a specifically defined Federal budget, however, the time has come for government authorities to recognize the human and social need of a growing number of physically handicapped and financially destitute elderly people who cannot qualify for Medicare assistance under the more stringent standards and yet are in no condition to return to their private abodes.

Under the present conditions they pose a stressful problem to the short-term general hospitals and to the physicians who assume the responsibility for their care.

Whenever and wherever private enterprise fails to provide adequate facilities, state or federal governments should intervene directly or indirectly to correct the situation.

Meanwhile Medicare benefits should be expanded to provide coverage for longer and lower levels of care, whether preceded or not by an admission to a short-term hospital.

If no solution is to be found, it is easy to predict that the cost of Health Care for the aged will continue to rise with the increase of the older age population, when many of these elderly patients will be admitted over and over again to acute hospitals either because of early relapses or other complications caused by neglect.

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In Memoriam
Wallace James Baker, M.D.
1916-1974

Dr. Wallace J. Baker of 30 Meadowview Road, Holyoke, Massachusetts, died at Holyoke Hospital on January 2, 1974.

Born in Plattsburgh, New York, on February 6, 1916, Dr. Baker received his bachelor of science degree from the University of Vermont in 1937 and doctorate of medicine from Middlesex Medical College in 1942. After serving an internship at St. Anne's Hospital in Fall River, Massachusetts, and a residency at the Holyoke Hospital, he entered into the private practice of medicine in Holyoke during 1946. Prior to his untimely demise, he devoted most of his practice to the specialty of dermatology.

Dr. Baker served on the medical staff of the Holyoke Hospital and the Holyoke Soldiers Home. He was a member of the Massachusetts Medical Society and the Hampden District Medical Society. From 1951 to 1953, he served in the U.S. Army Medical Corps during the Korean campaign.

To his family, friends and associates deepest sympathy is extended.

Editorial Correction—Please Note

The reader's attention is called to an editorial correction. In the December 1973 issue of the Hampden Hippocrat, under the title "Highlights from the November 1973 HDMS Executive Committee Meeting" on page 19, the third from the last paragraph, within the first sentence is a substantive error which does not reflect the Executive Committee's opinion or statements. The error is that of Secretary and Editor alone. An abridgment of that portion of New Business should read: The society felt it could perform an extra service for its members by establishing a list of physicians willing to do insurance exams. The list which would contain the names of new members of the society might be furnished by the executive secretary to any inquiring insurance agent. It was felt that this group of physicians would most benefit from such referrals. At one point in the discussion the fact entered that Emergency Room physicians were often called upon to carry out insurance exams; there was no expression by the committee members that this should not be done. It was then decided that the Hampden Hippocrat should indicate that physicians willing to do insurance exams should contact Mrs. Purdy and she will prepare a list for presentation to any inquiring insurance agent. The first sentence was unintentionally garbled and not caught in reading the proof.

W.E. Stevens, M.D.—Editor

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Highlites of the January Executive Committee Meeting

The Executive Committee of the HDMS convened at 7:09 PM Tuesday, January 12, 1974 in the Society's offices. In attendance were Drs. Asinas, Bloom, Cummings, Goldberg, Janovsky, Kelley, Kraus, LaMarche, Moore, Sheehan, Stevens and its President Dr. Zacarian and the delightful Viv Purdy. Dr. Paul Mc Kenna represented the dental society.

Correspondence: Two items were received: the first—from Dr. Omar T. Pace and it concerned the Comprehensive Health Care Program, the second —from Dr. Warren Platt, which was referred to Dr. Maurice Boivin and his Legislative Committee.

Old Business: Guideline material from the AMA was forwarded to a HDMS member, who had requested assistance in a matter of ethics. The committee again reviewed past correspondence and recommendation concerning hospitals' policies over charges made for abstracts of patient's records.

Procedures were discussed and outlined to help in settling disagreements of physicians within the HDMS. Misleading phraseology in the December issue of the Hippocrat was a case in point; a correcting statement will be published. The problem of confidentiality, third parties and the interrelationship of privileged communication between patient and physician will be explored at the February meeting of the MMS Council; concern over the problem was expressed by all present.

Dr. Stoler requested that the Medical Charges Review Committee be changed to the Medical Charges Review Committee and Peer Review Committee until such time as the Health Care Foundation of Western Massachusetts, Inc. assumes some of the tasks. The request was approved.

In a break during the proceedings, Dr. Eugene Boss, Jr., Mr. Beaudry and with Dr. Mozden as a guest, presented for initial evaluation a commendable project of the Medico-Legal Affairs Committee. It is a conjoined effort of the HDMS and the Hampden County Bar Association, Mr. Beaudry is Dr. Boss' counterpart for the Bar Association. These gentlemen present a proposal entitled "A Medical Arbitration Plan." The plan will be published in the Hampden Hippocrat and will be discussed and voted upon at the annual meeting in April. The Executive Committee gave its approval to the plan.

New Business: Dr. Zacarian and Mrs. Purdy have been investigating ways to ease the physician's problems of obtaining gasoline for his professional automobile. Mr. Harold Murphy, representing the Bay State Gasoline Association, is working on a program of assistance.

Springfield's Mayor Sullivan has given the Civil Defense unit of the city the task and responsibility for handling the fuel shortage. A special telephone number for emergency service will be made available and emergency vehicles will be utilized so that physicians can reach a hospital, if unable to do so under their own power.

A member of the Valley Press Club will be honored during the Annual Meeting for efforts which have been instructive to citizen-patients and which have strengthened the HDMS public image.

With no further business, the meeting was adjourned at 9:15 PM.

Summarized and Submitted
by the Secretary
Walton E. Stevens, M.D.

ARTICLE:

Hampden County Proposed Medical Arbitration Plan

PURPOSE: The purposes of this plan are two-fold:

1. To prevent, where possible, the filing in Court of actions against physicians and their employees for professional malpractice situations where the facts do not permit a reasonable inference of malpractice:

2. To make possible the fair and equitable disposition of such claims against physicians as are reasonably well founded.

Both physicians and attorneys recognize that the filing of a malpractice claim in court, however medically unjustified it may be, can cause substantial harm to the practice and reputation of the physician involved. Both physicians and attorneys recognize that persons having legitimate and meritorious grievances against physicians have encountered difficulties in substantiating their claims with expert testimony in Court.

BASIS: A joint agreement between the Hampden District Medical Society and the Hampden County Bar Association.

JURISDICTION: This arbitration plan may include claims made against physicians who are members of the Hampden Medical Society whether such claims arise in Hampden County or elsewhere. Claims may also be made against a hospital.

SUBMISSION OF CLAIM TO PANEL: Either the patient or physician may voluntarily request arbitration. Claims against a physician or hospital shall be heard regardless of participation or consent by the physician or hospital. (cont.)

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COMPOSITION OF HEARING PANEL: The panel will consist of two (2) physicians, two (2) attorneys and a Chairman, who may be an attorney or a former Judge. A list of physicians who are willing to be arbitrators shall be prepared by the President of the Hampden Bar Association. The President of the Hampden Bar Association shall also prepare a list of attorneys or former Judges who are willing and qualified to act as a Chairman of an Arbitration Panel. These lists shall be submitted to the American Arbitration Association. When a claim is made names of four attorneys, four physicians and two Chairmen shall be submitted to the parties by the American Arbitration Association. Any proposed arbitrator may withdraw. Any party may reject any or all of the arbitrators proposed initially. Selection of the final panel shall thereafter be made by the American Arbitration Association from those names not rejected from the initial list of proposed arbitrators. In the event an insufficient number remain in any category the American Arbitration Association shall fill vacancies without right of the parties to reject such arbitrators. If a field of medical specialty is involved, one of the physicians selected shall be a specialist in that field.

TYPE OF HEARING: Informal with both lawyers and both parties present at all times during presentation of testimony. Witnesses to be present only during their individual presentation of testimony. Commercial arbitration rules of the American Arbitration Association shall apply to all hearings except where inconsistent with express provisions of this plan.

PRESENTATION FOR REQUEST FOR HEARING: Written narrative by attorney presenting the claim. Agreement of confidentiality of hearing by both parties and attorneys.

FINDINGS OF THE PANEL: Secret ballot, Chairman also casts a vote but withholds and this only counts in case of a tie. Panel may not be polled. Decisions made by majority of those voting. The issue is determined on whether there is probable cause to believe that professional negligence exists and if so whether there is probable cause to believe that the claimant sustained any injury as a direct result thereof. A finding on the amount of damage is made.

RESULT OF FINDING FOR PHYSICIAN: Panel recommends that no suit be filed or if filed discontinued. This finding is binding on the claimant. Before a claim is heard all claimants including those with companion claims such as the spouse of a claimant or parents of a child must agree in writing to be bound by an adverse finding of the Panel. In the event that one of the claimants is under a legal disability such as being a minor or incompetent a guardian must be appointed to present the claim. Wrongful death claims shall be presented by a personal representative appointed by the Probate Court. A guardian or personal representative shall agree in writing to be bound by an adverse finding of the Panel and must have authority for the Probate Court to enter into such an agreement.

RESULT OF FINDING FOR CLAIMANT: Panel recommends that claim be settled and attempts to arbitrate such a settlement. If no settlement can be reached, the Hampden District Medical Society will present the names of two (2) expert medical witnesses who will willingly testify for the claimant.

CONFIDENTIALITY OF THE PROCEEDINGS: Complete confidentiality, no records of the proceedings shall be maintained after the decision. A record of the disposition of the case shall be maintained. Exhibits are returned to parties.

RULES OF EVIDENCE: Rules of evidence do not apply, witnesses may be called, sworn or unsworn statements may be received, copies of records and exhibits may be produced without formal authentication.

FEES: The claimant shall pay a $75.00 filing fee to the American Arbitration Association. The respondent shall also pay $75.00 to the American Arbitration Association. Arbitrators shall service without compensation.

PENDING: Suits claimed may be submitted under this plan regardless of whether a law suit has been filed.

Eugene G. Boss, Jr. M.D.

Editorial: Rule by Decree

We can all rest easy; there are enough benevolent dictators in Washington and Boston these days to guarantee that the public shall receive the finest medical care for actual disease and preventive care for everyone else. Their method is simple: Rule by decree. That's all there is to it; they merely replace the judgment of highly-trained, skilled, and experienced physicians with the stroke of a pen to spew out the most idiotic, unworkable, and obstructive rules imaginable. Unfortunately, their actions are legal and binding.

Here's the way it happens. Congress or the General Court takes up some health problem and passes an idealistic law containing high-sounding phrases. Opposition is extremely difficult without using arguments that would tend to place the medical profession in a position against improving the public health. These laws are then turned over to an administrative body such as the Department of H.E.W. at the federal level or the Department of Public Health at the state level. These administrative bodies then promulgate rules to implement the law and we must abide.

In Massachusetts we have an additional "monkey on our backs" in the form of a Public Health Council made up essentially of lay people and, to further confuse the issue, a Certificate of Need Law. Both of these gems are under the administration of Governor Sargent. The net effect is to control the practice of medicine by controlling the hospital by the type of disease a hospital may admit for treatment and the facilities they may have to accomplish the task. These are powerful controls via a subtle socialistic and bureaucratic approach.

Occasionally, the paper work clerks take suggestions made by a prestigious body, such as the American College of Surgeons, and, with a few significant changes to give them firm control, they rewrite them into the law. The problem of cancer treatment is their latest play toy. My interpretation of recent proposals is that it would become impossible to treat a cancer patient in all but a few hospitals in the State. Of course, the M.M.S. is opposing this.

It is hard to deny that the cost of modern medical care in the hospital setting has skyrocketed due to many justifiable factors and that unnecessary hospitalization must be curtailed. However, joint effort between government and the medical profession is the key to success. My own experience with Boston indicates that the administration is interested only in issuing decrees for political publicity and is not looking for effective solutions. We, as the providers of health care, would like to continue to perform our sworn task without crippling rules. Perhaps someday we'll have an administration capable of transforming the ideals of a law into a practical approach by drawing on the vast resources of knowledge within our profession.

James D. Allen, M.D.
Executive Councilor

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The following article, "Arbitration of Medical Malpractice Claims" authored by John F. Lillard III was published in The Arbitration Journal Vol. 26, No. 4 1971 pp 193 – 218. Mr. Morris Stone, Editorial Director of the journal which is the publication of the American Arbitration Association, was kind enough to allow the article to be reprinted in its entirety. Dr. Eugene G. Boss, Jr., Chairman of the Malpractice and Medico-Legal Affairs Committee of the HDMS felt that this article would best explain the concepts of medical-legal arbitration and would best provide the background for his article which appears on page 16 entitled "Hampden County Proposed Medical Arbitration Plan" of the February issue of The Hampden Hippocrat.

The broadside was so printed and it is suggested that it be read before Dr. Boss's article. The Executive Committee of the HDMS has given its approval of the proposed medical arbitration plan and wishes to inform the membership that the plan will be discussed at the April 30, 1974 meeting and if found satisfactory by the membership, will be tentatively adopted. The Hampden County Bar Association is proceeding along similar lines. If both societies are in agreement, the arbitration plan (as perhaps finally modified) will be activated and utilized.

This is a tremendous step forward for our two professions and it is to be much encouraged. Reader comment and input is actively sought. Please forward your thoughts, comments and opinions (favorable and unfavorable) to Dr. Boss, Jr. The Hippocrat will be glad to publish pertinent letters in its March issue; the deadline for receipt will be February 28th.

Walton E. Stevens, M.D., Editor-in-Chief

Article: Malpractice

ARBITRATION OF MEDICAL MALPRACTICE CLAIMS
Condensation of Article by John F. Lillard, III, published in The Arbitration Journal, Vol. 26, No. 4, 1971, pp. 193-218†*

Arbitration has for about twenty years served as an alternative to medical malpractice litigation, in some cases without denying wrongfully injured patients access to the courts. In many cases, attorneys and physicians have found that the courts are ill-equipped and the law unclear in the malpractice area, and that medical experts are unwilling to testify against fellow physicians. Because malpractice claims involve technical facts peculiar to the medical profession, and because litigation involves publicity and delay, private and expedient arbitration has been employed by medical and bar associations to relieve crowded court calendars and to predetermine malpractice disputes with a greater degree of expertise. In some instances, pure arbitration is used in malpractice cases, where by contract a patient agrees before treatment to submit any malpractice claims which might arise to arbitration and not to litigation and agrees to be bound by the award.

Emerging as a pre-trial mediation procedure of great merit is the "malpractice screening panel." In a number of states, either by court rule or by agreement between medical and bar associations, screening panels provide convenient arbitration or mediation forums for potential plantiffs to try the merits of a malpractice claim, to get pre-trial discovery, and to obtain expert witnesses, allowing only meritorious cases to proceed to trial.

However, in states where neither arbitration nor screening panels are employed, a striking increase in the number of malpractice claims is having destructive effects upon the medical profession.[1] As physicians are faced with the increased likelihood of en-

countering a lawsuit resulting perhaps in devastating and eccentric jury verdicts,[2] malpractice insurance premiums are becoming prohibitively expensive, and public confidence in the medical profession is being shaken. Furthermore, because doctors who are malpractice defendants suffer anxiety and loss of time and reputation, they are forced to practice wasteful "defensive medicine," cautiously treating patients as potential malpractice claimants, refraining from using new methods of treatment, and ordering excessive tests, x-rays, consulting doctors and other diagnostic procedures as safeguards against possible liability for negligence. As a result, a patient is required to bear the extra expense of medical care and to sign forms of consent, waiver, release, and authorization as a condition to treatment.

In metropolitan areas where medical malpractice suits are most frequent, the court docket is often several years behind, requiring a doctor to endure the anxiety of a pending lawsuit and an atmosphere of forced settlement. Often the revered jury system is unsatisfactory, because in medical malpractice cases complex medical fact situations are in many instances beyond the mental capabilities of some jurors. Even the trial of a malpractice suit itself has lengthened; extensive depositions are necessary; doctors are taken away from their practices and gossip about malpractice claims flourishes in their communities.

Almost everything about the arbitration or mediation process is calculated to appeal to a doctor or a busy hospital administrator. The procedures are simple, requiring a single hearing, carried out in the privacy and businesslike atmosphere of an arbitration chamber, the evidence of which is not a matter of public record, and the proceedings of which are brief and inexpensive.[3]

Malpractice Cases Submitted To Pure Arbitration

The litigation process in malpractice cases may be eliminated entirely by providing for pure arbitration, if the doctor-patient relationship is created by contract wherein an arbitration clause might be inserted.[4] Indeed, it has been suggested that an arbitration clause be inserted in all Blue Cross and Blue Shield plans.

The Ross-Loos Medical Group of Los Angeles has required an arbitration contract with patients for forty years in a prepaid health-care plan which requires a subscriber to sign a contract for future medical care, including the following arbitration clause:

> In the event of any controversy between the subscribing group and the subscriber or dependent, or the heirs at law or personal representative of the subscriber or dependent, as the case may be, and Ross-Loos, when involving a claim in tort, contract or otherwise, the same shall be settled by arbitration.

The Supreme Court of California upheld the validity of the arbitration clause and the use of arbitration for settling of such disputes:

> The arbitration provision in such contracts is a reasonable restriction, for it does no more than specify a forum for settlement of disputes.[5]

The language of the decision does not appear to limit arbitration to pre-paid health-care plans. However, the validity of an agreement to arbitrate might be challenged on the basis of undue influence or adhesion, because a patient in immediate need of medical care is asked by a physician to sign an agreement to arbitrate and has thus an unequal bargaining position.

In 1969, eight Southern California hospitals embarked upon a demonstration project in the use of arbitration for present, not future, medical care, under the auspices of the local medical and bar associations. Under that plan, when a patient checks into a participating hospital, he is asked to sign a medical admission form including an "Ar-

bitration Option," but may delete the arbitration clause in the Conditions of Admission form simply by initialing a statement directly above his signature or by writing the hospital of his option to delete the arbitration clause within 30 days after his discharge. Then, according to the California supplement to the rules of the American Arbitration Association, either party may compel arbitration concerning malpractice or fees; parties may intervene, discovery is made under court supervision; lawsuits are stayed; the statute of limitations is not waived; joinder is permitted; and a hearing is required within ten days. All questions of fault and degree are decided by the arbitration panel, and the award is made according to a schedule of comparative negligence. The option plan has proved acceptable to patients, as 100,000 patients have agreed to be bound and only a few have rejected the option.

It is premature to declare successful the California pilot plan or any arbitration plan requiring an arbitration agreement before treatment, as many questions remain. Insurance companies ask whether arbitration will raise the number of claims, encourage settlement, lead to higher awards than a jury might give, cost comparably the same for defense as does litigation, and bind the executor of a deceased patient. A take-it-or-leave-it condition of hospital admission would destroy such a system. Yet arbitration by experts, either American Arbitration Association personnel or physicians, attorneys and judges, would presumably promote awards based upon knowledgeable medical aspects of a malpractice suit which are more responsive to the needs of the judicial system. It is hoped that it will cause a sharp drop in the total amount of compensation paid to patients, more settlements prior to an arbitration award, more rapid disposition of claims, and less adverse publicity of malpractice.

Malpractice Cases Submitted To Screening Panels

A relatively new device to accelerate the disposition of medical malpractice actions, to diminish the number of malpractice suits which are filed without adequate cause, and to provide expert testimony for those patients who do have legitimate claims, has taken form in the malpractice "screening panel" established in twenty-three states. While the exact composition and function of these panels vary from place to place, the object is to make available, both to the patient who feels aggrieved and to the physician whose treatment is disputed, a forum in which the problem may come nearer a solution without the expense and publicity of a court proceeding. Even the American Arbitration Association administers programs of this kind, where there is more faith in professional arbitrators. Except in New Jersey, where the panel's decision may be binding under some circumstances, these panels issue opinions which are merely advisory. In no area is a patient compelled to submit his claim to the panel instead of proceeding to court. Hence these panels are more in the nature of mediation boards than arbitration boards.

In some states, the medical society has what is known as a "review panel." This is merely a panel of physicians which tells the malpractice defendant doctor whether he should fight or settle the claim against him. When an action is filed, the physician notifies both his insurance carrier and the panel, which is appointed by the medical society. At the hearing, the physician and his counsel present only his side of the problem.

"Medical expert panels" of physicians have also been established for the purpose of consulting with attorneys before trial in malpractice cases and providing expert witnesses. Selection of this panel is by the local medical society, according to the area of specialty involved in a given case, from a list maintained for the purpose, election to which is annual.

A different approach is the establishment of what is known as a "joint screening panel." These groups function in areas such as Tucson, Arizona, Denver, Colorado, Reno, Nevada, Albuquerque, New Mexico, New Jersey, and recently New York. These panels consist of both physicians and attorneys appointed by the area's medical society and bar association. The number of members of the panel varies from place to place, as do other aspects of their procedure.

Either side may request that the panel hear the matter. If the complaining patient either initiates or agrees to the panel's acting, he must agree to furnish all medical and hospital records without claiming privilege. The hearings are quite informal, yet no panel member may later be called as a witness in any action. Normally the panel arrives at one of two decisions: either that there is evidence that supports negligence and causation, or that the evidence is insufficient. If the patient prevails and evidence is found, then the medical society agrees to make an expert witness available to him at the trial.

The joint panel in Pima County, Arizona is referred to as an "arbitration" screening procedure. Under that procedure, the process is initiated by filing with the panel a brief statement of the facts, after which a hearing is called and the panel's medical expert testifies in the presence of both parties. The panel does not decide disputed issues of fact or the amount of damages. If the panel finds no substantial evidence to support the alleged facts, the attorney is expected to refrain from filing suit, "unless personally satisfied that strong and overriding reasons compel such action." Because of that hedge phrase, it is submitted that this plan is not as effective as it could be.

Under the New Mexico Plan the panel is composed of a committee of fourteen physicians selected by the Medical Association, and a committee of fourteen attorneys selected by the Bar Association. From the total of twenty-eight panel members, three physicians and three attorneys are selected by the respective medical and bar committee chairmen to hear any one malpractice case, and they serve one year terms. It is felt that a plaintiff's attorney will submit his claim to the panel because he is "morally compelled" to do so. Likewise, it is thought that plaintiff's attorneys utilize the system to determine whether they have a case, to secure expert medical witnesses, to be assured of some settlement, and to assure the client that he has no case.

In Columbus, Ohio in 1959, the Franklin County Bar and Medical Associations requested the American Arbitration Association to administer a joint screening panel plan. There the panel is made up of seven persons, three physicians and four lawyers, appointed directly by the American Arbitration Association from lists submitted by the Academy of Medicine and Bar Association to serve without compensation and to be free to disqualify themselves or to be disqualified by the Academy or the Bar. The procedure is governed by A.A.A. rules, as modified by the panel chairman, and the voting is by secret ballot, with no record of the proceedings except the finding itself. Significantly, the authority to enter into arbitration must come from the Ohio Probate Court, and the court binds all the parties. Furthermore, the basis of authority is not the patient's contract, but rather the agreement between the Bar Association and the Academy of Medicine. After suit is filed, either the patient or the doctor may demand arbitration. The parties may strike panelists, but when the A.A.A. fills the vacancies, there is no further right to strike. The finding of the panel is either probable cause of professional negligence and proximate causation of injury, in which case the panel recommends settlement or provides medical experts, or no probable cause, in which case the panel orders the plaintiff's attorney, a member of the subscribing Franklin County Bar, to discontinue his suits and the finding is binding on the claimant, in accordance with an agreement filed when the case is initiated. It is submitted that by using the services of the American Arbitra-

tion Association, the sponsoring associations have relieved themselves of administrative obligations and have increased public acceptance of the plan.

Under the "New Hampshire Plan," the Jurisprudence Committee of the New Hampshire Medical Society reviews all malpractice claims, decides whether claims should be contested or settled, and pressures insurance carriers into abiding by the Committee's decision. The Committee meets two or three times a year and invites the physician alleged liable, yet bars claimants and their attorneys from the proceedings. Somewhat like the "review panel," this program is not joint and not binding, and though it seems unfair, it has proven successful. In the long history of this committee, not a single case which the committee has voted to settle has ever gone to court.

Recently in New York, a plan has been drawn up which is called a "mediation panel." Effective in the Fall Term of 1971 of the New York State Supreme Court in Manhattan, the plan is administered by the Appellate Division, First Department and the panels preside over a "special part" of that court. The panels have only three members, a Supreme Court Justice, a lawyer, and a physician, and initially hear every medical malpractice case brought in New York Supreme Court in an attempt to arrive at an early amicable disposition. The plan evolved from a public conference sponsored in 1970 by the Inter-professional Committee of Doctors and Lawyers appointed by the Presiding Justice of the Appellate Division. The plan has no binding effect upon the parties but provides only a pre-determining "mediation" of the claims. The panels attempt to resolve one or more of the issues involved in the case, and it is expected that in some cases the basic issue of liability will be settled by the panels. The panel encourages the parties to come to an agreement, and any agreement is incorporated into a court order. The plan was promulgated not by doctors and lawyers but by the court itself in an attempt "to find alternative means of processing cases as part of . . . a continuing effort to bring calendars up to date," and thus relieve itself of the burdens of malpractice lawsuits. Medical specialists and experienced trial lawyers will serve on the panels as nonjudiciary "Special Mediators" to make the panels rich in expertise.

New Jersey Joint Screening Panel

The most significant approach to the medical malpractice joint screening panel was instituted in 1965 in the State of New Jersey, by Supreme Court rule. The New Jersey Plan includes a "binding option" which provides the same enforceability and standardized professional norms as pure arbitration. The medical profession and the legal profession seem to be pleased with its results, yet insurance carriers feel that the panels are weighted in favor of the patient and against the physician.

The "New Jersey plan" (Civil Practice Rule 4:21), like other joint screening panels, is a pre-trial procedure explicitly designed to discourage baseless actions and make expert witnesses available to claimants with meritorious claims; and it may be utilized after a lawsuit has been filed. An impartial screening subpanel of two physicians, two attorneys and a retired judge (chosen at random from a standing panel) previews the facts surrounding alleged malpractice and prejudges the merits of a submitted complaint to determine either that there is evidence that the physician was negligent and the patient was injured causally by the negligence or else that the evidence is insufficient. After an evidentiary hearing, the subpanel recommends to the claimant either that he abandon his claim if the subpanel finds no reasonable basis for the suit or that he settle the claim and refrain from instituting suit if the subpanel finds a reasonable basis. However, if the subpanel finds a reasonable basis, the claimant may sue on his claim, and the subpanel will, through the medical association, provide the claimant with expert witnesses in the appropriate medical field.

To initiate the procedure, either the injured patient or the doctor informally and voluntarily submits the claim to the

subpanel, and then written consent is requested from the doctor before the hearing is allowed. When the hearing is called by the Administrative Director of the Court, the claimant and doctor present their evidence, either narratively or by examination and cross-examination, and are required to submit all relevant medical records and other exhibits. To avoid publicity, the subpanel's proceedings are in camera, and all records, findings, and recommendations are confidential. At the conclusion of all evidence, the panel votes by secret ballot. The finding of the subpanel is either "We find that there is a reasonable basis for the claim" or "We find that there is no reasonable basis for the claim"; and if the latter, claimant's counsel is barred by court rule from appearing on behalf of the claimant in any further action on the claim. The panelists cannot be called as witnesses in the trial.

The New Jersey plan may be distinguished from similar plans in other states, for it includes a "binding option." In order to be provided with expert witnesses who will testify at a subsequent trial, the claimant must sign a binding agreement, in the nature of an arbitration contract, before the panel hearing that if he is not supported by the panel's findings, he will not institute any legal proceedings, or will dismiss a pending action, against the physician. If the panel does find his claim valid, the services of three expert witnesses will be made available to him; yet if he opts not to sign the agreement, experts will not be arranged for him, even if the panel finds in his favor. A claimant's failure to sign the "binding option" will invoke upon him the consequences of the so-called "conspiracy of silence," and he will find it difficult to persuade reputable doctors to testify in court. Indeed, where no actionable claim is found, the "conspiracy of silence" will be accentuated, because medical experts who learn that their able colleagues on the screening panel have found no cause of action will be further discouraged from testifying for the claimant. Thus, an adverse ruling in the subpanel hearing results in a preliminary determination of the merits of the case, which effectively precludes litigation. Likewise, a favorable ruling usually leads to settlement out of court, because defense counsel for the doctor and his malpractice insurance carriers are inclined to foresee difficulties of proof against a meritorious claim.

Two decisions regarding the New Jersey "binding option" have been rendered. The history and intent of the rules were reviewed in the 1967 case of Marsello v. Barnett.[6] In that case, the patient signed the agreement to abide by the subpanel's decision. After signing it, but before the subpanel heard the case, the patient advised the subpanel that he revoked not only his "binding option" but also his consent to the hearing itself. He had changed lawyers and obtained through the second counsel an expert witness who was willing, before any subpanel determination, to testify in court that there was actionable malpractice. Thus, the need for a subpanel hearing to provide expert testimony was obviated, and the claimant was prepared to prosecute his claim. The New Jersey Supreme Court, which had promulgated the rules, held that since the decision to appear before the subpanel was designed to be voluntary, the patient was allowed to change his mind, revoke his consent, and proceed directly to the court.

The "binding option" was firmly upheld in the 1970 case of Grove v. Seltzer.[7] In that case, the patient sought to revoke his consent after the subpanel heard the case and decided against him by a finding of non-negligence. The patient had changed his mind and wished to sue and be represented by the same counsel who had appeared before the panel on his behalf. He claimed that the only reason he had signed the binding option was that the physician had refused to appear before the panel if he did not do so. He claimed, therefore, that he had been subjected to "duress" and his signature on the binding option was invalid. However, the court found that his exercise of the "binding option" was voluntary, and that there could be no question that plaintiff clearly understood the consequences of his

action and chose to invoke the subpanel procedure in the hope of securing expert medical testimony, especially since he and his counsel signed the following statement:

> With regard to the above claim made, I agree not to institute any legal proceedings and to dismiss any pending legal proceedings against the named doctor(s) in the event the Professional Liability (Medical) Subpanel, after reviewing the claim, is of the opinion that there is no reasonable basis for it.

Accordingly, the claimant could not bring suit on his malpractice claim.

To one unfamiliar with the rules of arbitration, such a provision would seem an unconstitutional deprivation of a citizen's right to redress for damages in a court of law; but the right to waive the option to litigate a claim by arbitration contract has long been upheld as constitutional. Thus, with greater effect, an arbitration agreement signed in the wake of an injury, after the alleged malpractice, and fully voluntarily, must be upheld.

The New Jersey plan provides the best aspects of arbitration and the best of the joint screening panel. As in arbitration, the signature of a claimant binds him to drop his claim in the event that his claim has no merit. The only distinction is that the contract in the case of the New Jersey plan is signed not before but after the treatment, alleged malpractice, and injury. If the claimant chooses not to sign, he is not afforded the benefit of medical experts chosen by the medical society and he must seek the counsel of another lawyer to prosecute his meritorious claim.

Conclusion

The American Medical Association has taken no position with regard to arbitration in medical cases. Yet, it is submitted that arbitration agreements should be used by doctors and hospitals, because by their use medical malpractice cases can be removed from the courts where they no longer belong. The obvious problem with joint screening panels is the lack of uniformity, the patchwork of screening procedures. However, as the American Arbitration Association becomes increasingly involved, a uniform system may emerge. The proper forum for the resolution of medical liability suits is a panel of attorneys and physicians trained in the fields involved in the controversy, where an informed and fair determination can be made.

* Associate in the New York City law firm of Donovan, Leisure, Newton & Irvine. The article was written when the author was a student at Washington and Lee University Law School. It received the Lucius Eastman Arbitration Library's 1971 award.

† Copyright 1971 by the American Arbitration Association, Inc. Price for single copy of the Arbitration Journal is $2.50. Address: 140 West 51st Street, New York, New York 10010.

[1] The volume of malpractice cases against doctors and hospitals has reached the staggering proportion of 10,000 suits a year at a cost of 50 million dollars a year. Averbach, *Rx For Malpractice*, 19 Clev. St. L. Rev. 20 (1970). In a survey conducted by the American Medical Association, it was reported that one out of every six physicians practicing medicine today has had at least one malpractice claim made against him. 185 J.A.M.A. 789 (1963). The malpractice insurance rates for surgeons have had a sixfold increase from an average of $600 to $3,300 in a city such as Philadelphia; some insurance companies have dropped out of the field and are refusing to write any malpractice policies for any new physician moving into an area. Averbach, supra.

[2] Jury awards have reached unprecedented high levels. Within a recent twelve-months' period, there was a jury verdict of $1,500,000 for a Florida anesthesia paralysis, $1,400,000 for a similar California mishap, and $1,250,000 for a New Mexico scalp radiation burn case. Averbach, supra.

[3] An arbitration hearing can usually be obtained within a few months of submission. Records of the AAA for 1966 show an average time of about five months for a final award. In addition, most arbitration hearings can be completed in one day. The administrative costs of arbitration average about $60, and the shorter time consumed reduces attorney's fees, where there is no contingent fee basis. Further, settlement may be private without disclosure of court files, there is no danger of sentiment as in a jury trial, and there is no strict adherence to evidence rules. Note, *Arbitration of Medical Liability*, 211 J.A.M.A. 175, 176 (1970).

[4] A doctor-patient contract is usually implied from the relationship, but may be reduced to writing. A proposed model arbitration agreement, executed by a patient before treatment,

might be phrased as follows:

AGREEMENT TO SETTLE ALL CLAIMS BY ARBITRATION

In consideration of the above named Physician's agreement to undertake the treatment of the undersigned Patient, and in further consideration of the substantial professional services to be rendered to said Patient by said Physician, and in full acknowledgment of the dangers to said Patient which may be inherent in or result from said treatment, the undersigned Patient, the undersigned spouse of Patient and the undersigned Physician hereby respectively covenant and agree that each and every case, controversy, claim, declaration, suit, complaint, action or otherwise, whether in contract or in tort, which may hereafter arise for any reason or from any cause or source between or among any or all of said parties, their respective assigns, heirs, and/or legal representatives, shall be settled only in accordance with the Rules of the American Arbitration Association as hereinafter modified (see paragraph 3, below), and judgment upon the award rendered by the Arbitrators shall be entered in a Court of Record having jurisdiction thereof. The parties hereto further acknowledge their understanding and/or agreement:

1. That arbitration can provide a speedier, more efficient and more economical method of determining disputes or controversies between them than the normal determination by a Court or Jury.
2. That the parties have specifically been afforded an opportunity to discuss this Agreement with their respective attorneys before its execution.
3. That each party to an arbitration initiated hereunder shall have the right to use any discovery procedure which would have been available in a civil action pursuant to the [state] Court Rules and the Arbitrators(s) shall regulate such discovery.

Dated:.....
Patient.....
Spouse of Patient.....
Physician.....
Witnesses:
.....
.....

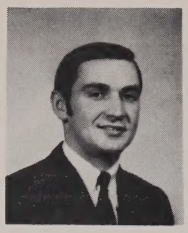
[5] Doyle v. Guiliucci, 60 Cal. 2d 606, 43 Cal. Rptr. 697 (1965).
[6] 50 N.J. 577, 236 A.2d 869 (1967).
[7] 56 N.J. 321, 266 A.2d 301 (1970).

* * *

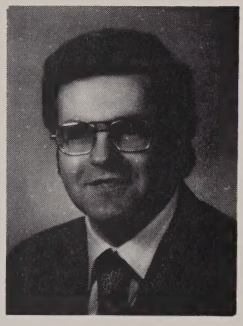
END OF BROADSIDE

New Members December 1973

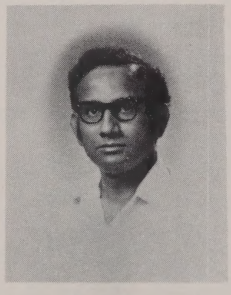
Raymond J. Anton, M.D.
60 Court St.
Westfield, Ma. 01085
Born: March 19, 1944
Medical School: University of Vermont College of Medicine 1970
Internship: Hartford Hospital July 1970-71
Residency: Hartford Hospital July 1971-June 73
Children's Hospital, Boston November 1972 to January 1973
Specialty: Anesthesia



Freeman P. Botnick, M.D.
125 Liberty St.
Springfield, Ma. 01103
Born: August 8, 1941
Medical School: Albert Einstein College of Medicine 1967
Internship: Rhode Island Hospital Providence, R.I. 1967-68
Residency: New York University—Bellevue Medical Center N.Y., N.Y. 1970-73
Specialty: Opthalmology



Dhipati Chanda, M.D.
207 Elm St.
Holyoke, Ma. 01040
Born: Jan. 17, 1938
Medical School: N.R.S. Medical College, Calcutta 1960
Internship: N.R.S. Medical College, Calcutta, India
Residency: Different Hospitals in England and Scotland from 1963-1971
Specialty: OB-GYN



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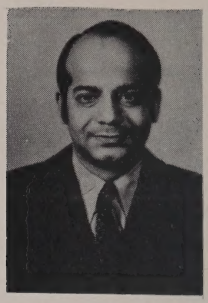
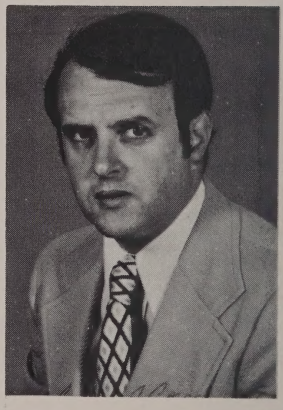
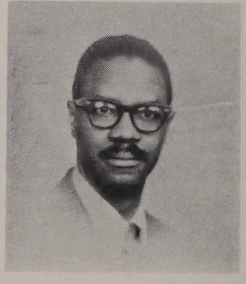
Kalyan K. Chattopadhyay, M.D.
Holyoke Hospital
575 Beech St.
Holyoke, Ma. 01040
Born: Feb. 9, 1938
Medical School: R. G. Kar Medical College & Hospital University of Calcutta 1963
Internship: Fordham Hospital, Bronx, N.Y. 7-1-66 to 6-30-67
Residency: 1. Junior Resident in Anes. 1-1-68 to 12-31-68, Fordham-Misericordia Affiliation, Bronx, N.Y. b. 2nd year Resident in Anes. 1-1-69 to 12-31-69 Montefiore Hospital & Medical Center, Bronx, N.Y. c. 3rd year Resident in Anes. 1-1-70 to 12-31-70 Montefiore Hospital & Medical Center Bronx, N.Y. d. Fellow in Anesthesiology, 1-1-71 to 6-30-71 Montefiore Hospital & Medical Center, Bronx, N.Y. e. Fellow in Anesthesiology, 7-1-71 to 6-30-72 Hospital for Joint Diseases & Medical Center, 1919 Madison Avenue, N.Y.
Specialty: Anesthesia



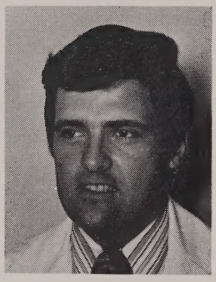
Louis A. Corsaro, M.D.
689 Chestnut St.
Springfield, Ma. 01107
Born: Dec. 14, 1942
Medical School: New Jersey College of Medicine 1968
Internship: D.C. Childrens Hospital July 1968-69
Residency: Columbia Presbyterian Medical Center—Babies H. July 69-71 Str. Ped
Specialty: Pediatrics



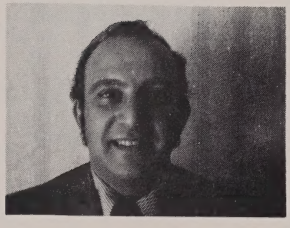
Ephraim Z. Edwards, M.D.
60 Court St.
Westfield, Ma. 01085
Born: Dec. 22, 1926
Medical School: Howard University 1952
Internship: Springfield Hospital Medical Center 1969-1970
Residency: Hartford Hospital 1970-1973
Specialty: Anesthesiology



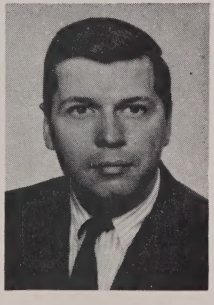
John P. Fitzgibbons, Jr., M.D.
Springfield Hospital Medical Center
759 Chestnut St.
Springfield, Ma. 01107
Born: December 3, 1938
Medical School: State University of New York, Syracuse 1964
Internship: Fifth and Sixth Medical Service, Boston City Hospital 1964-65
Residency: Fifth and Sixth Medical Service, Boston City Hospital 1965-66, University of California Hospitals 1968-70
Specialty: Internal Medicine and Nephrology



Stanley Glasser, M.D.
1111 Elm St.
West Springfield, Ma. 01089
Born: Oct. 1, 1940
Medical School: S.U.N.Y. Downstate Med. School 1966
Internship: Maimonides Medical Center 7-66—6-67 Brooklyn, N.Y.
Residency: Maimonides Medical Center, Brooklyn, N.Y. 7-67—12-68, 1-71—6-71
Specialty: Pulmonary medicine



Raymond J. Kusiak, M.D.
120 Maple St.
Springfield, Ma. 01103
Born: Jan. 16, 1939
Medical School: University of Virginia 1965
Internship: University of Kentucky Hospital, Lexington, Kentucky 1965-66
Residency: Duke University Hospital, Durham, North Carolina 1966-70 General Surgery—Otolaryngology
Specialty: ENT



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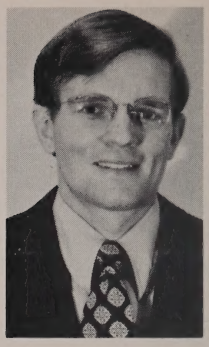
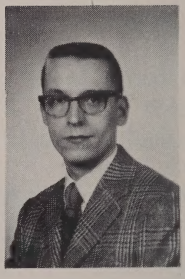
Anthony P. Lovell, M.D.
80 Congress St.
Springfield, Ma. 01104
Born: June 18, 1940
Medical School: Yale University 1967
Internship: University of California Hospitals 1967-68, San Francisco, Calif.
Residency: Univ. Calif. Hospitals, S. F. Calif. (1968-70), U.S.P.H.S. Hosp. S. F. Calif. (1970-72), U.S.V.A. Hosp. West Haven, Conn. (1972-73)
Specialty: Internal Medicine and Cardiology

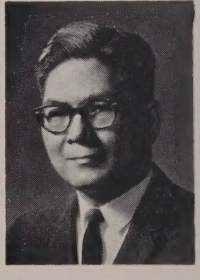


Robert H. Nenninger, M.D.
130 Maple St.
Springfield, Ma. 01103
Born: February 24, 1939
Medical School: Columbia University P & S 1965
Internship: St. Luke's Hospital N.Y.C. July 1965 to June 1966
Residency: Int. Med. St. Lukes N.Y.C. July 1966-June 1967, Hospital University of Pa., Aug 1969-Aug. 1972
Specialty: Radiology

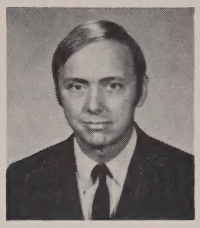


Oscar R. Nepomuceno, M.D.
70 Hubbard St.
Ludlow, Ma. 01056
Born: Feb. 20, 1937
Medical School: University of Santo Tomas 1963
Internship: Fordham Hospital, Bronx, N.Y., July 1964-June 1965 Rotating Internship
Residency: Methodist Hospital, Brooklyn, N.Y., July 1965-June 1969
Specialty: General Surgery

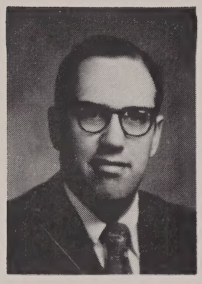
Jose C. Pangan, M.D.
Mary Lane Hospital
Ware, Ma. 01082
Born: July 20, 1935
Medical School: University of Santo Thomas, Manila Philippines 1959
Internship: Clark Air Base Hosp. 1958-1959 Philippines, Kings County Hospital Center, Brooklyn, N.Y. 1961 (Jan. to Dec.)
Residency: Kings County Hospital Center, Brooklyn, N.Y. 1962-1966 Fellowship same hospital 1966-1967
Specialty: General Surgery and General Medicine



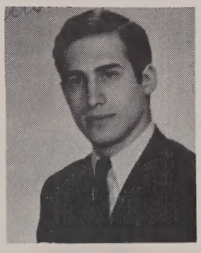
Stuart R. Rose, M.D.
Wesson Memorial Hospital
140 High St.
Springfield, Ma. 01105
Born: May 19, 1938
Medical School: Columbia University 1965
Internship: San Francisco General Hospital 1965-1966
Residency: University of California Hospitals, San Francisco 1966-1969
Specialty: Emergency Room



Eugene F. Russell, III, M.D.
130 Maple St.
Springfield, Ma. 01103
Born: Sept. 4, 1939
Medical School: University of Virginia 1965
Internship: University of Virginia Hospital, Charlottesville, Va. 1965-1966
Residency: University of Va. Hosp. 1966-67 Assistant Res. in Surgery, University of Va. Hosp. 1969-72 Assistant Res. in OB/GYN, University of Va. Hosp. 1972-73 Resident in OB/GYN
Specialty: OB/GYN



Arthur M. Sher, M.D.
130 Maple St.
Springfield, Ma. 01103
Born: March 26, 1944
Medical School: New York University 1969
Internship: Maimonides Medical Center, Brooklyn, N.Y., July 1969-June 1970
Residency: Albert Einstein College of Medicine, July 1970-June 1973
Specialty: Dermatology



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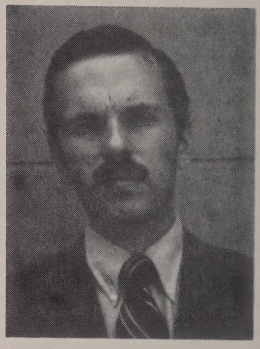
80 Congress St.
Springfield, Ma. 01104
Born: Aug. 20, 1940
Medical School: State University of N.Y. 1966
Internship: University of Kentucky Medical Center, Lexington, Ky., July 1966-June 1967
Residency: University of Kentucky Medical Center (General Surgery) 1967-1968, University of Michigan Medical Center (orthopedics) July 1970-June 1973
Specialty: Orthopedic surgery



Robert O. Valerio, M.D.
168 Bemis Road
Holyoke, Ma. 01040
Born: July 29, 1946
Medical School: Boston University School of Medicine 1970
Internship: St. Vincent Hospital, Worcester, Ma. 1970-1971
Residency:—
Specialty: Emergency Medicine

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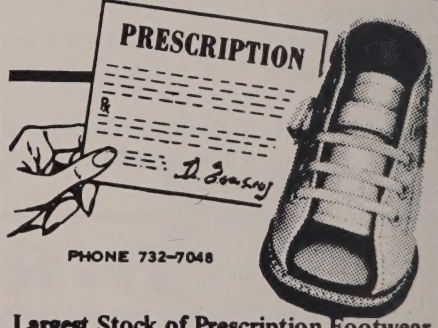

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Letter to Editor

To: Steven A. Minter, Commissioner
Department of Public Welfare
Boston, Mass.

Dear Sir:

We have received your letter of Nov. 9, 1973. In reply to your request for comments, I should like to make the following points:

1) All invoices leaving this office have a patient's name on them. All files in this office—as well as in most doctors' offices and in hospitals—are filed alphabetically by patient's name. When your "Claims Remittance Advice" is sent to us with the notation "Case Unknown" in place of a patient's name, it is virtually impossible for us to check to *whom* a particular invoice refers or to submit a corrected bill. (Such "Case Unknown" invoices returned to us as of 12/7/73 amount to $1,-500.00.) The local Medical Aid office has suggested that we change our filing system to refile thousands of invoices by number. Such a procedure would also entail making two carbons of all future invoices in order to file one by patient's name and the other by number. Such additional clerical work would cost innumerable hours and add immeasurably to my expenses.

2) Even assuming that some of these rejects can be identified, it is often impossible to know *why* an invoice is not being paid. Your code "J" ("Not identifiable as eligible cardholder") seems to cover a variety of errors—yours as well as ours. How, then, can we submit corrected invoices if we don't know what to correct?

3) Some of the invoices being rejected are marked "H" (Time elapsed between service date and or receipt of ELB, and the date of receipt at Medical Claims Control exceeds six (6) months".) Everyone of those invoices was clearly marked "Tracer". Some pertain to the first six months of 1972 when funds were frozen and no payments were made. (Amount involved in such billing is approximately $1,200.00) In all these cases, the procedures followed were those suggested by the local M.A. office in telephone conversations during last Summer and Fall.

4) Some of the invoices being rejected are marked "L" (Duplicate invoice or service-paid previously.) These bills were clearly marked as requests for *additional* payment. The procedure was approved both by Mrs. Maar in the local M.A. office and by Mrs. Curtis at the Regional Medical Advisor's office. The additional payments involve either:

a) A revised fee schedule which became effective 7/1/72. This revision was announced in your letter dated 9/26/72 and received in this office in the Spring of 1973. (The amount involved here is about $1,200.00.)

(cont.)

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b) A request for additional payment where one item on an invoice has been paid and another has not.

c) A request for additional payment where payment seems insufficient for the particular service rendered.

5) Our local M.A. office has returned to us (unpaid, of course) approximately $5,000.00 in tracers submitted to that office during the last year. The notification reads: ". . . In order for this billing to be processed for payment, it will be necessary for you to furnish us an actual copy of the claim originally submitted . . . " However, we have previously received from the Springfield office, assurances that photo-copies of our ledger cards would serve as proof of the date of original billing where ever such originals are not available. Since these tracers date back to 1968, this is often the case because your older stationery was not in duplicate-sets. In fact, we have even been refused payment in cases where copies of original invoices were submitted because these copies were on plain bond paper rather than carbons of PA 7 for services rendered *before* PA 7 was in use.

Considerable expense has been incurred in verifying these invoices and submitting them *according to the instruction* given to us. Furthermore, in many cases, it is simply not possible to comply with your insistance on copies of originals which are no longer available.

6) In your letter you say that the local M.A. office has the responsibility for maintaining the eligibility of clients and that questions pertaining to eligibility be referred to them. This morning my secretary was on the telephone for *more than one hour* trying to check out *one* patient's status at the M.A. office. She finally had to attend to other duties—but we still do not know whom to bill for services rendered to this patient. This is *not* an exceptional case. We have many more patients whose eligibility is equally hard to ascertain.

7) You further state that in order to trace missing payments, it will now be necessary to obtain approval from Westborough to rebill. There is only one telephone number at Westborough which services all of the Commonwealth. Is it any wonder that it is almost impossible to reach the office because of continual "Busies"?

In conclusion, it seems to me that it is up to your department to devise a system of payment that allows a physician to collect legitimate payments for services rendered with a minimum of paperwork. Fees payed by the Commonwealth are already considerably below those charged to private patients. By further increasing our expense, you are pushing those doctors who are still willing to treat M.A. patients to the point where such treatment must be stopped. If it is the intent of the government of Massachusetts to deprive those of our citizens who are unable to provide for their own medical services of health care, this should be stated honestly and publicly.

May I have a prompt, *detailed* answer explaining how payments in each of the above categories can be expedited. Of course, I must reserve all my legal rights and remedies.

Very truly yours,

Walter F. Tauber, M.D.
Provider No. 2075601

cc: Atty. David Burres
S. Zacarian, M.D. Pres. H.D.M.S.
Louis P. Alfano, M.D. Vice-Pres., M.M.S.
Edi Editor, Mass. Physician
Editor, Hippocrat

Editor's Note: Your comments on Dr. Tauber's letter, or simular experiences are invited. In this letter he has effectively elucidated all our problems.

Letters to the Editor (cont.)

Our Cooperative Link Toward Better Patient Care

Dear Sirs:

Quite recently, through the concerted effort of one J. J. Zadworny, M.D., we the members of the Pharmaceutical profession through the sponsorship of the Western Mass. Pharmaceutical Association, were asked to express our opinions and "air our gripes" surrounding the workings of the medical profession which effect us directly.

Let me start out by stating that as pharmacists we consider ourselves to be significant members of a team dedicated to public health maintenance. We are the prothesis of the physicians ink pens and naturally, we function at our ultimate best when expected to act always within the boundaries of laws set forth around us—even if, on occasion, they seem difficult to comprehend or accept.

FOR INSTANCE: Schedule 2 drugs CANNOT be taken via the telephone EXCEPT on a true Emergency basis. These drugs include: Percodan, Demerol, Amphetamines and now, as of November 6, 1973, any Methaqualone Rx (Quaalude, Parest and Somnifac).

It is not uncommon for a physician to call and order 30 or more Percodan for instance and be very upset with the pharmacist if he refuses to accept his prescription.

These more popular drugs and various others are within this schedule because of their abuse potential. Should an emergency arise requiring the use of these drugs, ONLY a 72 hour supply can be dispensed without a written prescription. Such prescriptions must be received in writing from the physicians within 72 hours or the physician becomes liable to fines, and the pharmacist is liable to the same if he fails to report said physician to proper authorities.

Second on the list is failure to include BNDD numbers on blanks which are not so pre-printed. In the past this two letter seven digit number was required on all prescriptions falling within the five control schedules. However, effective immediately all welfare billing forms for any legend drug require this number before consideration for payment is initiated.

The third significant request we have is that the number of refills be clearly marked on the prescription. This would save time for all of us. Many of us have been reprimanded by physicians for filling their prescriptions when only a line was drawn where "# of refills" is indicated on their blanks. This could be interpreted as 'NONE AT ALL' or 'INDEFINITELY'.

It is our every hope that through combined efforts and cooperation, a stronger liason will be established by our professions and the ultimate result will be significant patient care improvement.

We fully realize also, that each of us is not without fault and we gratefully welcome any comment or suggestion that will improve our techniques.

We are, collectively, most grateful for this opportunity to express our views.

Professionally yours,
Mrs. Marguerite C. Johnson
B.S. Reg. Ph.
Secretary W.M.P.A.

KING'S PHARMACY
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117 MAIN STREET
CHICOPEE FALLS — 592-1651

Dear Sir:

A unique medical malpractice trial demonstration featuring top trial attorneys from across the nation will be presented on Saturday, March 30, 1974, by the American Society of Law and Medicine, Inc. The event will take place at the Boston University Law School Auditorium, 765 Commonwealth Avenue in Boston and is being co-sponsored by the University's Center for Law and Health Sciences.

The purpose of the "mock trial" is to demonstrate to physicians, lawyers, students and other professionals in the medical, legal and insurance fields the important issues and practical aspects raised in potential medical-malpractice litigation. According to *Society* President, Dr. Elliot L. Sagall, the topic is of great importance in light of today's mounting threats of medical malpractice suits. "There is a growing concern that limited availability and increasing cost of insurance protection will result in a deleterious effect on health-care professional and hospital providers concerned with rendering quality medical care while attempting to contain the spiraling costs," stated Dr. Sagall.

At issue in the "mock trial" will be questions of negligence, assault and battery, breach of contract and lack of informed consent in an unsuccessful vasectomy. The demonstration will include opening and closing arguments as well as expert witnesses testifying under direct and cross examination. The presiding Judge will be the Honorable John J. McNaught of the Superior Court of Massachusetts. Trial lawyers for the day will include noted Attorneys Leonard Decof, Robert O'Reilly, Meyer Goldman, Francis C. Newton, Bernard A. Dwork, Charles Dunn, Jr., Thomas E. Cargill, Jr., Francis H. Miller, Lawrence J. Smith, John A. Norris, Paul Sugarman, Douglas Danner, Kathleen Ryan Dacey, John Dunn, Barry C. Reed, and James Vaccarino. Serving as witnesses will be Doctors Elliott L. Sagall, Robert Gould, and Arthur Herbst. Professor Thomas F. Lambert, Jr., Editor-in-Chief of the Association of Trial Lawyers of America, will moderate the program and provide a running commentary. Program chairman for the event is George J. Annas, Director of the Center for Law and Health Sciences of Boston University School of Law and Editor-in-Chief of MEDICOLEGAL NEWS, a publication of the American Society of Law and Medicine, Inc.

Admission is $15.00 ($12.50 for Society members). There will be a nominal fee of $1.00 for legal and medical students, medical interns and residents. Further information may be obtained by contacting the American Society of Law and Medicine, Inc., 454 Brookline Avenue, Boston, Massachusetts 02215, or by telephoning (617) 353-2910.

The American Society of Law and Medicine, Inc., is a recently formed, non-profit organization designed to promote continuing medicolegal education primarily by acting as a catalyst enabling single-disciplined professional organizations to combine programs focusing on those problems and issues of law, medicine and insurance. The Center for Law and Health Sciences is devoted to fostering educational and research activities in the area of legal medicine.

Sincerely,
Dr. Elliott L. Sagall
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Series Article:

A Matter Of Rules

Part One

A medical society or any other organization that purports to represent its members on various subjects must conduct regular meetings. These should be in the form of a deliberative assembly to ascertain the sense and will of the assembly and to express this in an intelligent and authoritative manner. In order to accomplish this, there are two prerequisites: Firstly, we must be organized properly—this is the function and necessity of having bylaws; secondly, our deliberations need to be conducted in an orderly fashion—this is the purpose and importance of having rules of order.

These rules are often referred to as parliamentary law, indicating the basis of our modern rules of order as originating with the customs and rules for conducting business in the English Parliament. However, Common Parliamentary Law soon gave way to modifications based on the same enduring principles on which our nation is founded—the right of the majority to decide, the right of the minority to be heard, the right of absentees to be protected. In 1876 General Henry M. Robert printed and subsequently revised what is now widely known as "Robert's Rules of Order." Other revisions have taken place. The MMS and the HDMS have adopted revised Robert's rules. There are other modifications of the rules, such as Cushing's. To quote General Robert:

"The object of Rules of Order is to assist an assembly to accomplish in the best possible manner the work for which it was designed. To do this, it is necessary to restrain the individual somewhat, as the right of an individual, in any community, to do what he pleases is incompatible with the interests of the whole. Where there is no law, but every man does what is right in his own eyes, there is the least of real liberty."

In subsequent articles, I hope to shed some light on how these rules are implemented with specific reference to motions, resolutions, and debate.

JAMES D. ALLEN, M.D.

Editor's Note: The AMA, MMS & HDMS have adopted Alice Sturges' "Standard Code of Parliamentary Procedure" 2nd Edition as their guide for presiding officers, committees and members.

Letter to Editor

Dear Doctor:

I should like to extend to you my appreciation of your past support of all of organized medicine and my sincere hope that you will continue your membership in 1974.

I trust that you will find useful the enclosed brochure which, for the first time, gathers together in one place a description of the many tangible benefits of AMA membership. You may also find this booklet suitable for presentation to a non-member. There is a tear-off membership application card which may be used.

The great growth in membership among young physicians, who are just finishing residency training or who are still in a health staff position, has been most exciting. It seems clear that increasing numbers of physicians are becoming appreciative of the intangible benefits which relate to the efforts of organized medicine to defend their professionalism and their professional freedoms. These defenses can only be made effective by collective actions such as those which the AMA has been prosecuting so vigorously with our legislators and with our allies in society at large.

It is my belief that virtually all physicians should be with us in these conjoined efforts, and your help in recruitment would be most appropriate.

Cordially,

Russell B. Roth, M.D.

Editor's Note: The brochure can be obtained from your HDMS Executive Secretary, Vivian Purdy.

Hampden Capsules & News Items:

Those physician members of the Hampden District Medical Society willing to perform insurance physical examinations should submit their names to the Executive Secretary—Mrs. Purdy, so that she can prepare a list to be furnished to inquiring insurance agents.

The Department of Public Health will hold an evening public hearing in the auditorium of the Springfield Municipal Hospital on Monday, February 25, 1974. The subject will be the final (seventh) draft of the proposed Rules and Regulations for Cancer Management in Hospitals and Clinics. All physicians with an interest in cancer management are urged to attend and express themselves. A copy of the draft is to be found in the HDMS office. For further details contact Mrs. Vivian Purdy and/or her staff.

January 17, 1974

To: District Secretaries

From: Thomas Gephart, M.D., Secretary The Massachusetts Medical Society

The official membership of your district medical society as of December 31, 1973, is as follows:

Active fellows: 455
Senior fellows: 77
Total: 532

Your district, therefore, is entitled to 21 elected councilors in accordance with Chapter III, Section 6 of the bylaws.

The councilors elected at the annual meetings of the district societies in the spring of 1974 do not take office until after the annual meeting of the state society in May in accordance with the bylaws. Their first official Council meeting as an elected councilor will be in October 1974. However, they are welcome to attend the annual meeting of the Council on May 22, 1974, Georgian Room, Statler Hilton, Boston, at 10:00 a.m.

NOTICES:

To: District Medical Society Secretaries

From: (Mrs.) Judi Linden, Placement Office, (Secretary to Mr. Spencer) The Massachusetts Medical Society

Re: Placement Service

The Massachusetts Medical Society operates an active Placement Service. Each day, the office receives personal letters from physicians requesting information about *available* positions in Massachusetts.

Unfortunately, at present, we cannot provide them with adequate information about openings in every field. The Society, therefore, would like to expand its placement services to be of help to all physicians. In order to do so, we would appreciate your help in making our services known to the members of each district society so that we may be advised of openings as they occur.

We should then be advised of the type of work involved, necessary qualifications of applicant, location of the position, date the physician is needed, income range, etc. We will so inform physicians contacting the Society of the opportunities to practice in the state.

Your help is greatly appreciated. If you have any other suggestions or references concerning physicians' placement, I'd appreciate hearing from you.

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Tufts University School of Medicine announced appointments to its clinical staff of the following physicians.

In Medicine	Academic Appointment
Carl E. Cassidy, M.D.	Clinical Professor of Medicine
William M. Davis, M.D.	Asst. Clin. Professor
John J. Fitzgibbons, Jr., M.D.	Asst. Clin. Professor
Ralph E. Gianelly, M.D.	Asst. Clin. Professor
Burritt L. Haag, M.D.	Asst. Clin. Professor
Jesse G. Hafer, M.D.	Asst. Clin. Professor
Howard G. Turner, M.D.	Asst. Clin. Professor
Leroy Shear, M.D.	Assoc. Clin. Professor
In Surgery	
Robert Emery, M.D.	Asst. Clin. Professor
Jas. W. S. Hartshorn, M.D.	Asst. Clin. Professor
Omar T. Pace, M.D.	Asst. Clin. Professor
Richard J. Chabot, M.D.	Clin. Instructor
Richard A. Courtney, M.D.	Clin. Instructor
Barry Sachs, M.D.	Clin. Instructor

Congratulations are in order for these men who are living up to their Hippocratic Oath and taking time from their busy practices to teach the future physicians. Hopefully, some will find the Pioneer Vallie a place to live and practice.

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Courtesy Medical Society Magazine Group

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Schedule For Upcoming NCME

February 25-March 10

Treatment of Pulmonary Embolism, with William Hall, M.D., Director of the Pulmonary Function Unit, Strong Memorial Hospital; Assistant Professor of Medicine, University of Rochester School of Medicine, Rochester, New York.

The Five-Minute Joint Exam, with John J. Calabro, M.D., Chief of Rheumatology, Worcester City Hospital; Professor of Medicine, University of Massachusetts Medical School.

Detecting Open Angle Glaucoma, with Jerome N. Goldman, Attending Ophthalmologist, Washington Hospital Center, Assistant Clinical Professor of Ophthalmology, Howard University Medical School, Washington, D.C.

1974 AMA Sponsored Meetings

March 22-23: National Conference on Health Care of the Poor, Shoreham Hotel, Washington, D.C.

April 1-3: Third Quality of Life Congress, Marriott Motor Hotel, Chicago.

April 18-20: 8th National Congress on the Socio-Economics of Health Care, Town and Country Hotel, San Diego.

April 25-26: 27th National Conference on Rural Health, Detroit Hilton Hotel, Detroit.

June 22-27: Annual Convention, Chicago.

August 19-22: Western Hemisphere Nutrition Congress, Americana Hotel, Miami Beach.

September 9-10: Congress on Occupational Health, Marriott Motor Hotel, Chicago.

November 30-December 4: Clinical Convention, Portland, Oregon.

INTERNATIONAL CERTIFICATES OF VACCINATION

A traveler may have his International Certificate (PHS-731. Rev. 9/66 or 69) confiscated and his trip ruined if the form has been improperely or incompletely filled out. If the instructions which appear on every form are followed by both physician and traveler, no problem regarding its completion should arise. It is imperative, therefore, that:

1. The proper form be used (PHS-731. Rev. 9/66 or 69).
2. It is signed (not printed or stamped) by the vaccinating physician.
3. It be dated properly – day (numerals), month (written), year (numerals), (ex. 19 April 73).
4. Under smallpox, the origin (manufacturer) and batch number be written in.
5. The certificate be officially validated.

No certificate will be validated unless Items 1–4 are in order. Certificates may be validated by local boards of health or health departments, authorized agencies, or by the Division of Communicable Diseases, Western Mass. Public Health Center, University of Mass., Amherst, Massachusetts 01002. Properly completed certificates, sent to the above address with a self-addressed stamped envelope, will be validated and mailed the day they are received.

The Poet's Corner

Twinkle, twinkle, politician;
Fly your legislative mission.
Think up lovely little bills;
To cure our real or fancied ills.
Regulate the cost of meat;
Let the Russians buy our wheat.
Never mind the soaring prices;
We are used to fiscal crises.
Give our grants or pass a pension;
Just to show your good intention.
What care we if taxes rocket;
It only hurts us in the pocket.
Subsidize the tobacco crop;
But warn all smokers they should stop.
Blast the medical malefactors;
But pay the local chiropractors.
Promise folks to buy their pills;
And pay up all their doctor bills.
But then be sure the doc gets piles
of retrospective claim denials.
Hit us doctors of the nation;
With price control discrimination;
But just remember, chum, our PAC
will help decide if you come back.

RUSSELL ROTH, M.D.
President AMA
(From PaMPAC Briefs
Pennsylvania PAC)

Salt, Sand, Grass and Gulls

The sea to me will always be
An unbelievable gift from God,
A thing majestic.
Sometimes angry, and serene
And, always as a child
I stand and stare
At her wonderfulness
Endlessly repeating her tides return.

John F. Speight
A friend of the Hippocrat

Private Reflections on Euthanasia

When I approach the Gates, which e'er
they be,
Heaven or Hell, I know not, do I care—
I've lived my life, and I have tried to see
My duty, and at least to do my share—
I want no transplant heart inside my
chest,
Plucked from a corpse still quivering
with life,
I want this tired body laid to rest
And not supported for continued strife.
Nor do I wish merely to gasp alone,
Or be a vegetable, much better dead,
Because some silly, simple minded
drone
Has quipped, "Perhaps the cure lies
just ahead!"
The right to live includes the right to
die—
To die in dignity as well as peace.
When all is hopeless, listen to my cry,
Allowing me the privilege of release.
So, my physician, also be my friend,
When I am terminal, grant me the end.

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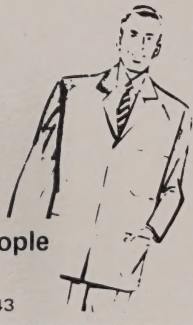

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Act III, Richard II
William Shakespeare

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